

## **PROFESSIONAL AND MORAL DEVELOPMENT IN MEDICAL STUDENTS: THE ETHICS OF CARING FOR PATIENTS**

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### **INTRODUCTION**

The young physician-in-training faces arduous tasks. Knowledge must be absorbed, and skills must be mastered. But, becoming a physician is a moral as well as an intellectual task. The attitudes and values that a young physician adopts will determine the way he or she practices, and be equally as important as intellectual and technical proficiency. Physicians-in-training are young adults. They have emerged from adolescence into adulthood, hopefully with a firm image of themselves and a self-awareness of their values and inner feelings. Erik Erikson thought that the principal task of adolescence was to establish identity (1). As young adults, these individuals now move to the task of developing intimate relationships, the capacity for commitment to partnerships and affiliations (1,2). This includes marriage and family, but may also include close associations with friends and teachers, and relationships to patients and colleagues (3). Erikson conceived of the opposite of intimacy as the withdrawal into isolation and self absorption. One can visualize the challenges and dangers in the professional development faced by young physicians from this perspective, establishing functional, healthy relationships with patients and colleagues, versus dysfunctional distancing or withdrawal. The ability to establish functional relationships may hinge upon having developed personal values and identity sufficiently strong to withstand the stresses, both physical and psychological, of medical training.

In a series of courses in which medical students worked in small groups with faculty longitudinally in years one and three of medical school, my colleagues and I were able to observe the students as they developed professionally (4–6). This provided us with a vivid snapshot of medical students at developmentally important times, though we have not observed them so closely during residency training, another crucial period when changes are likely to occur. Particularly using “critical incident reports” written by the third year students, but also

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numerous intense discussions with students, we developed several hypotheses concerning their professional and moral development (7–9).

### **STUDY POPULATION**

#### **THE STUDENTS AND THEIR COURSE**

Our course was offered to over 800 students in the first and third years of medical school over a seven-year period (4,5). Small groups of 8–10 students and several faculty met weekly. The course, referred to as “Patient-Doctor,” espoused values and had an educational philosophy. Our goal was to produce humanistic physicians. Our values included tolerance for the viewpoints and beliefs of all members of the group, compassion and respect for patients, and embracing the importance of understanding patients’ perspectives and their experiences with illness. Our curriculum was semi-structured. Topics, such as “dealing with death and dying” or “giving bad news to patients” were chosen for the students (4,5). Learning exercises using role plays, video tapes, and bedside interviews with patients were suggested (6). But groups were given latitude in structuring their discussions. Attention was paid to the process of learning, examining how students discussed the content, how they talked to patients, and how they worked with others.

The students were about 40% female. Their interests were not narrow, since many had well defined interests and talents outside of science and medicine, in music, philosophy, literature and other fields. For the most part, they warmly embraced the content of our course. Intellectually, they were far advanced, capable of complex abstract reasoning.

A good bit of our insight into the students’ exposures to patient-care, their efforts to develop professional identities, and their values and moral outlooks pertaining to these early clinical experiences came from the students’ “critical incident reports” (7,8). Critical incident reports are short narratives of events judged to be particularly meaningful by the participant in the events (10–12). Our medical students wrote such reports at the beginning, in the middle, and in the later part of their third year. We used the reports for the students to reflect within their small groups on the meaning and implications of their experiences on the wards. The technique opened avenues for a reflective educational experience by the students, whose main efforts were otherwise aimed at practical work on the wards (13).

## CRITICAL INCIDENT REPORTS

Within virtually every critical incident was a moral or ethical issue, which generally occurred in the context of the student's professional development, or as we viewed it, his or her struggle to acculturate into medicine (7). This was richly embedded within a narrative account of personal experience. It should be emphasized, these ethical issues and struggles to become a doctor were real. They were not classroom exercises.

Several examples of critical incident papers will illustrate recurring themes. Three that leapt out at us are: (a) the students developed strong empathic identifications with their patients; (b) ethical issues were defined in terms of caring and compassion for the patient, rather than abstract moral principles; and (c) the stories were marked by difficulties in acculturation or socialization; frequently there were clashes between the values held by the students and ways of doing things on the wards (7,8).

*Example:* A student had as a patient an unfortunate young woman who had had a total colectomy with perforation of the anastomosis of her rectal pouch during a follow up sigmoidoscopy (8). The chief resident (Dr. R.) sarcastically disparaged the abilities of the attending surgeon (Dr. S.) within hearing of the medical student and other residents. Orders were given at morning rounds that conflicted with notes by the attending surgeon. "This came to a head over the task of removing the patient's two Jackson-Pratt surgical drains. Dr. R. requested that they be taken out individually with premedication on postop day 6; consequently (the student) told the patient what the procedure would be and that she would feel minimal pain. That very afternoon, before they were able to act, Dr. S. attempted to remove both drains without premedication. He had to stop half way because she was in agony" (8). Angry at what he presumed to be Dr. S.'s negligent care, and the sense of being made to look foolish in front of the patient, the student grappled with the decision whether or not to tell the patient that Dr. S. might be incompetent. Despite having developed a strongly empathic relationship with his patient, the student decided to remain silent. He neither let her know his misgivings about her care, nor let the senior doctor or medical team know of his concern about their disruptive conflicts. On discharge, the patient confided to him that she was aware that Dr. S. might not be the best technical surgeon, but trusted Dr. S. because of his kindly and comforting demeanor.

Here is a student unsure how to behave professionally. He is unsure how literally to interpret the remarks of his colleagues. He is uncertain

of his obligation to his patient, and of his professional obligation. Looked at from the ethical point of view, the issue pits his sense of responsibility to care for his patient against insecurity regarding the course of action to take.

Another critical incident illustrates a student's similar dilemma. This student described Mrs. M., a homeless woman, poorly dressed, malodorous and hostile, being advised to have the resection of a malignant tumor (7). The attending surgeon, impatient with her hostility, provided factual information on the indications for surgery, then watched impassively as the irrationally angry patient left the room. Frustrated, the surgeon made some "less than flattering remarks about Mrs. M.'s personality" (7). The student described feeling quite upset by the outcome and opined that perhaps this patient had previously had negative experiences with doctors, and might have responded to a more understanding approach that could win her trust. In fact, the student later contacted Mrs. M. and convinced her to return for an explanation by a different physician.

A number of elements common to critical incident reports are present here. The student's strong empathy for his patient may seem natural, but those of us who have worked on the wards will recognize that empathy for problematic, even hostile patients, especially if from the underclass, is frequently lacking. The student also adopted a relatively sophisticated approach to communicating with his patient, likewise obviously indicated, yet commonly lacking. The ethical dilemma in this case, similar to that above, involves his perceived duty to place his patient's welfare first, which may place him at risk of being labeled a trouble maker. This calls into question his sense of responsibility to care for the patient. Fairness is another element. The student felt that this disheveled, homeless woman was given less consideration by the surgeon than someone with more social standing would have received. The student's sense of fairness is hyperacute, compared to those more inured to disparities in how different classes of people are treated.

The two stories quoted above are typical in several ways. The majority of students found it difficult to accept the way things were done on the wards. Empathy, placing themselves in their patients' shoes, powerfully pervaded almost all of the reports (7-9). Empathy was the heart of the moral viewpoint of virtually all the students. Examples abounded. Because of empathizing with the patients, students objected to performing procedures, such as arterial blood gases on dying patients, or to being asked to perform tests, such as a spinal tap, on patients who preferred a more experienced operator. Students expressed concern over information being withheld from patients regard-

ing their diagnoses or about inadequately obtained informed consent. After a resident told a patient "this operation is your only chance," one student thought the patient "was browbeaten into agreeing to the operation" by a resident who "used the specter of death almost as a threat" (7). Frequently, such students found themselves being the liaison between unfortunate patients and the health care teams. Especially with demanding or difficult patients, students described being the only ones who saw the patient's side of it. Only a minority of students described teachers who empathized with and were advocates for their patients. In fact, students resisted their acculturation or socialization into the medical team, because they perceived the team did not see things from the patient's perspective.

Feudtner and Christakis made similar observations (14). Their cases, derived from a required ethics course for third year students, were as dramatic as ours. They identified conflicts with authority as a key component of students' ethical issues (15). Students' dilemmas involved procedures performed despite patients' objections, progress notes written despite not having examined the patients, and being asked not to tell patients the results of their tests, or, for example, not to awaken an intern to supply pain medication to a suffering patient (15). Feudtner and Christakis were shocked by some of the "blunt portrayals of duplicity and abuse" (14,15). Their students' ethical dilemmas mostly hinged around subservience to authority. Students were reluctant to question superiors, and felt unable to act on principles (14,15).

In a survey of 1,853 medical students, Feudtner and Christakis reported that 61% of respondents witnessed behavior by a member of their team that they thought was unethical (16). Forty percent had done something unethical themselves in order to "fit in with the team, or for fear of a poor evaluation" (16). The majority of students felt that "some ethical principles were eroded or lost" (16).

## **THEORIES OF MORAL DEVELOPMENT IN YOUNG ADULTS**

Kohlberg and others described levels of moral development based on longitudinal followup of children, adolescents and young adults (17-19). Based on discussions of cases designed to create moral dilemmas, Kohlberg reported that young persons from several societies passed through the same sequence of levels. There was overlap but once in a level, subjects' answers almost all reflected thinking within that level, and they preferred the highest attainable level. These moral levels are more or less related to developmental stages of reasoning. Children around age seven

progress from intuitive thinking to concrete logical thought. Formal operational thinking is later attained by many young adults. This includes understanding the relations between elements in a system (17).

Kohlberg described young children as being in a level of moral development characterized by doing right to avoid punishment. Later, they enter a level characterized by being good in order to meet obligations and fulfill their duties to parents and important others. Individuals at this level might do right in order "to avoid the breakdown of the system" (17,18). Kohlberg thought that some young adults advance to the highest or principled level. They can examine issues from the point of view of social contract and individual rights. Seeing that different values and opinions are held by others, such persons may reason that the social contract requires upholding normative rules in the interest of impartiality (17). Although persons at this level see that some rights and values, including respect for life, individual autonomy and justice, are universal, only a few individuals actually govern their actions by universal ethical principles. These few individuals may adopt a stance of civil disobedience because of a personal commitment to universal principles (17).

Based on longitudinal studies of women, Gilligan identified a second moral "voice" in addition to that described by Kohlberg (19,20). "One voice speaks of equality, reciprocity, justice, and rights. The other speaks of connection, not hurting, care, and response" (20). She identified a tension between these ways of thinking, which she thought were gender-related. In her view, males develop in ways that emphasize independence; they value justice and autonomy. Females define themselves in relation to others and value care and connection (20). A concern expressed by proponents of this view is that morality built upon justice emphasizes impartiality, impartiality could promote aloofness or indifference. Getting at the inadequacies of moral thinking based purely on principles, other thinkers emphasize the context within which moral problems occur, a web of relationships, dependencies, suffering, self-deception, uncertainty, and individual character (21). They point out that morality is played out in messy, real life situations (21). In medicine, moral issues are always embedded not only in pain and fear, dying, and chronic illness, but also within the patient's concerns and personality, and how these interact with the doctor's abilities and style (22,23).

### **MORAL LEVELS OF MEDICAL STUDENTS**

Reading over 100 critical incident reports yielded one obvious hypothesis. Like the women described by Gilligan, both male and female

medical students operated mostly within the moral domain defined by *compassion and caring*. They defined the moral issues in terms of responsibilities to patients. Fairness was important to them but in the context of their obligations to the suffering and less fortunate. We did not seek to define gender-related differences in the students, but for the most part, students in both sexes seemed to adopt the same moral viewpoint. Students could discuss utilitarianism and social contract theory, so perhaps their approach was to some degree integrated, compassion and caring informed by the principles of justice and autonomy (19,20). But the moral viewpoint adopted by most medical students was based on compassion and caring.

### **THE ROLE OF EMPATHY: DETACHMENT VS. OVERINVOLVEMENT IS THERE AN EMPATHY TRAP?**

The students' conflicts with their teams were most often couched as violations of personal values or principles. The student "took the patient's side against the doctors, who took their own side." So, to the students, becoming a doctor was problematic. It meant compromising one's principles in order to fit in, or join the team (7,14,15). The emotional nature of this conflict is readily apparent if understood as conflict with a moral viewpoint based on compassion and caring, also based on identification with those less fortunate, underdogs, the sick. Salient features of the ethics of caring include focusing on the relationship to one person. This allows for the special responsibility one has toward dependents, such as children, spouses, parents, friends, or patients. In this ethics, one may be partial. One has emotional attachments. The ultimate value is love rather than justice. This ethics says, I have a special responsibility for those dependent on me. Such an ethics fits with the practice of medicine, which is altruistic, and sacrifices the physician's personal needs for the welfare of the patient. We observed no examples of emotional overinvolvement by students with their patients, leading to dysfunctional care (9). We did observe that most students identified with their patients much more so than their teams. To give up the emotional attachment in order to fit in is where the trap lies. We know that many physicians become distant and emotionally detached from their patients (24–28). The strength of the students' empathic bonds with their patients could paradoxically eventually require an opposite reaction in many young physicians, emotional detachment in order to function on the team.

It seems noteworthy that the students perceived their teams to be

operating at a developmental level lower than their own moral level. Whereas the students operated according to their values (compassion, caring, respect and fairness to patients), the teams appeared to operate at the lower level of doing right to please others and function within the system. In some conflicted reports, the team's motivation appeared to be avoiding punishment. Critical incidents sometimes described students fearing retribution or punishment if they didn't go along with superiors.

What are the implications of the perceived need to regress to a developmentally more primitive level in order to function? It may account for the difficulty acculturating. Not only were principles being violated, but some students were being pushed into childish behavior. It would be astounding if medical students eventually regress to a morally lower level themselves, but the evidence at hand suggests they may. We know from many observations that young physicians do in fact modulate their values—highly empathic, compassionate concern for patients, a keen sense of injustice—when they become house officers. Feudtner and Christakis reported that some students accommodated to the teams, and others tried to postpone the responsibility to act ethically (14). Sixty-two percent of students believed their moral principles had eroded (16). Others reported that 77% of students experience detrimental changes in attitudes (29). They become part of the team by not struggling so much over principles. Now, it may be necessary for some evolution to occur if medical students are to function as physicians, but the question is, if we understand part of it as regression, shouldn't we intervene to handle it better?

### **THE ROLE OF REFLECTION IN ASSISTING MORAL DEVELOPMENT**

In my estimation, most of the 800 or so students who participated in our "Patient-Doctor" course kept their values alive, also their empathy for patients, and their brightness and inquisitiveness in the third year of medical school. Having watched for many years the so-called formal curriculum of ethics lectures fail to have much influence on the students, I was much gratified by the obvious impact of our "Patient-Doctor" course. Small-group teaching methods worked. I want to emphasize this by repeating it: small-group teaching methods worked, perhaps largely because students described their most unpleasant, awkward, even profoundly disturbing experiences, and discussed their honest feelings in the groups. This aided the students to become explicitly self aware of values, which otherwise could have remained



inchoate, unexpressed and subject to repression. In studying the "informal curriculum," which occurs in hallway conversations, dormitories, and late night encounters outside of the formal curriculum, Hundert described the adaptive process by which students "repress unpleasant experiences to get on with the work at hand" (30). He suggested it may be necessary for students to derepress traumatic memories if they are to be good mentors to those below them. Our small-group methods accomplished this through well described group processes, whereby as members of a small-group come to trust each other, they tentatively disclose personal concerns. Eliciting support from others in the group enhances comfort and facilitates additional self-disclosures. This leads to a discovery by each member of the group that the others have experienced similar struggles, a validating process termed "universalization" (6,31). A sizable number of our students were also able to incorporate empathy and compassion into their interactions with patients. These students seemed less conflicted in their doctor roles (7). We hypothesize that the group support encouraged the students to keep ethical values and principles alive and make them a part of their work with patients (5-9).

Critical incident reports are only one of a number of methods that allow honest discussion. But discussion alone, even at deep levels, may ultimately prove insufficient for students as they struggle to adapt to real life dilemmas, while advancing through a hazily understood hierarchy, and dealing with sick patients, anxious families, long hours, and much uncertainty regarding their roles. Changing the "culture of the wards" is a daunting task, a battle for the minds and hearts of the individual students, residents, and faculty. An important additional benefit of courses like "Patient-Doctor" is involving large numbers of the clinical faculty (4,5). Being involved in intense discussions with students will undoubtedly influence their behavior on the wards. The same may occur as large numbers of former students advance to residency training. Hafferty says that the "hidden curriculum" of the medical wards establishes norms that "warn students against becoming too reflective or introspective, and warn against critically examining the forces that are shaping their professional identities" (32). Can we change this "hidden curriculum"? Perhaps we can influence it with our teaching. For example, Hundert's work suggests that ward teams, as opposed to operating at a low moral level, may establish values of their own. This could go wrong. Some have reported that residents exhibit a cynical attitude; shrug off suggestions of superiors as irrelevant, unappreciative and self-serving (33). It could be one view that ward teams have a "samurai" culture, focused intensely inwardly on

achieving excellence, while ignoring the larger issues of the patients around them. Yet, observers like Hundert and perhaps Charles Bosk identified values underlying residents' attitudes and behaviors that would need to be appreciated by anyone wanting to change the system from within (30,34). Residents value hard work in serving patients; they value the desire to learn. As one resident put it in criticizing a student, "she did not appear chagrined enough when the answers she volunteered were wrong" (30).

The resolution of a moral dilemma does not always require compromising moral principles. It may at times be approached by recognizing how different sets of values might work together. Could we keep alive the empathy and compassion of medical students into the residency years, but find ways to blend this with the residents' natural striving for professional mastery. Could we explicitly frame the residents' work as serving their patients with excellence? The two perspectives—student and house staff—then might reinforce each other. Kohlberg's work suggests we will not encounter many students willing to adopt civil disobedience in response to compromising their principles. A realistic approach would critically examine the interplay of residents' and students' values, to help the students adjust to legitimate demands of patient care without suppressing their moral principles.

## CONCLUSIONS

Becoming a doctor in many ways involves building a professional identity. Each medical student finds his or her own ways of interacting with patients. These include various degrees of empathy or detachment, willingness to listen or not, wanting to hear patients' perspectives, and so forth. The danger lies in the possibility that students will create narrow professional identities that leave out much of what we call "humanism" in medicine. Constant effort to keep alive core values, validate their importance, and learn to incorporate these into professional work can enable the students to include their natural warmth, empathy and understanding in their professional identities.

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## DISCUSSION

**Bondurant, NY:** I'd like to express appreciation from everyone in this room for a magnificent piece of work, magnificently presented, and much needed, as reflected by the fact that I am very confident that the statistics that you have gathered in one place are universal throughout academic medicine. I congratulate you on the follow-up that you have done so far. One of the great problems in any educational intervention is to know whether the effects are lasting or not. I wonder and hope that you have plans for some kind of follow-up evaluation as the years go by to see whether this group will differentiate itself in any way from its peers.

**Branch:** There are many people that worked on this new pathway project started by Dean Tostefson at Harvard Medical School. I know that there is one group who is accomplishing some longitudinal follow-up. One of our dilemmas is that as busy educators trying to organize our courses, we had not enough time for the study of our work, but we are pursuing some follow-up and I am now looking at residents as they progress in the system at Emory to see what happens to their moral values during their residency program.

**Friesinger, Nashville:** Very sobering data. Unfortunately, I find them very credible. In reference to other aspects of trying to change the culture, I am curious about whether you have an arrangement whereby house staff, and particularly faculty, would get feedback. It seems to me that is a critical piece of the process.

**Branch:** What we have attempted to do on a small scale and we never quite had the resources to do this on the scale it was done in the medical school, is to establish some of these small group processes among the house staff. Dr. Wolf and I did some of that with the interns at the Brigham. Again, we are doing it at Emory with the primary care residents. The purpose in the process of reflection and self awareness that comes from that is to attempt to bring out these ideas and principles among the house staff so that they can look at what they are doing. There is also a very interesting phenomenon called the hidden curriculum which Ed Hunder and others have studied. I think we need to look closely at the culture of the house staff. My belief is that they have a set of values, that they are focused on excellence, but they are very inwardly focused and what we need to do is to transform or reframe that focus of their culture, if you will, more to put the patient into the perspective of excellence in the service of the patient as opposed to just inwardly focusing on excellence.

**Carol Johns, Baltimore:** Some of your good thinking has metastasized to Hopkins and it is my pleasure to participate in our Physician-in-Society course for the third and fourth year students. We have both third and fourth year students in the same group and I think that has an interesting impact. We have used the "critical incidents" approach for

some of the sessions, following the model that you have described. It is certainly quite easy to discover that the pressure of time is one of the factors that results in this obvious lack of adequate communication and expression of compassion. I can't help but think that if the students reflect on this, as they proceed further into their residency, it will occur to them that those pressure of time have an effect. There have been some reported incidents that originated from your institution, in fact, wherein a medical student who later became a resident learned that one of the students in subsequent years reported some behavior wherein she herself had demonstrated the same shortcomings that she had been so concerned about when she was a student. Using some of this for resident groups in some weekly session where they can reflect upon all the pressures that are upon them can't help but enable them to pursue a real true compassion that we all want to demonstrate in our care of patients.

**Branch:** I agree. I think it is ironic that the part of medicine that makes it most rewarding to the physician is that which you can't do without devoting the time to it. It does take time.

**Brust,** New York: Did your sessions address patients' and physicians' attitudes toward alternative medicine?

**Branch:** We had some sessions on alternative medicine which were popular with the students. It was basically the exploring of different ideas of alternative medical practitioners so that we would understand what they were doing and also look at some cultural implications of choices of alternative treatments by different ethnic groups.

**Owen,** Philadelphia: First, let me congratulate you on covering a very sensitive and needed discussion. The Alpha Omega Alpha, the honorary society, has a series of audio-visual tapes that deal with certain subjects. These are tapes by Leaders of American Medicine and many of the individuals are in this audience. I might point out that one particular tape comes to mind that your students might appreciate observing. That is a tape of Dr. A. McGhee Harvey who addressed the role of the physician, how patients develop immediate trust in most physicians and disclose information to that individual that they would rarely disclose to anyone. The whole role of ethical consideration of being a doctor who takes care of a patient, provides health care is discussed in this tape. Although I think all the tapes are very enjoyable and very informative, this particular tape might be appropriate to be reviewed by your students in regard to the role of a physician in providing health care.

**Branch:** We certainly could profit from linking our current efforts with those that have traditionally been present in medicine and could profit by keeping that tradition alive.

**Owen:** Those tapes are available by calling the Alpha Omega Alpha office and they are free to review. They are most informative and cover some of the very sensitive issues, as you have addressed today.